WELCOME

Irvine Smile Design
General, Cosmetic and Implant Dentistry

PATIENT INFORMATION

Date: _____

Patient Name:

_____
Last Name First Name Middle Initial

Preferred Name: _____

SS #: _____ DOB: _____ Age_____

Assigned sex at birth: ___ Male ___ Female

Optional - Preferred pronouns: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____

Occupation: _____

Employer/School: _____

___ Married ___ Widowed ___ Single ___ Minor
___ Separated ___ Divorced ___Partnered for ____ years

How did you hear about our office?

_____

PHONE NUMBERS

(To reach you regarding appointments)

Home Phone: _____

Work Phone:_____

Cell Phone: _____

Best time and place to reach you: _____

IN CASE OF EMERGENCY CONTACT

Name: _____

Relationship: _____

Home/Cell Phone: _____

Work Phone: _____

DENTAL INSURANCE

PLEASE PROVIDE INSURANCE CARD TO RECEPTIONIST

Who is the subscriber on this account?

Name: _____DOB: _____

Relationship to Patient: _____

Insurance Co.: _____

ID/SSN: _____

Employer: _____

Insurance Co. Phone: _____

ASSIGNMENT AND RELEASE

I authorize my insurance company to pay Drs. Mogari, Brown, Soleimani, & Wasfi all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Irvine Smile Design to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand payment is due in full at the time of treatment. I understand that I will be charged for a broken appointment fee when less than 48 hours notice is given and this amount must be paid before any future care can be given.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative **Date**

DENTAL HISTORY

Reason for today's visit: _____

Date of last dental visit: _____ Date of last full mouth x-rays: _____

How often do you floss? _____ How often do you brush? _____

Is there anything you want to change about your smile? _____

Name: _____ **Date of Birth:** _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bad breath	___ Yes	___ No	Canker sores	___ Yes	___ No
Bleeding gums	___ Yes	___ No	Cold sores	___ Yes	___ No
Cigarette, pipe or cigar smoking	___ Yes	___ No	Orthodontic treatment	___ Yes	___ No
Clicking or popping jaw	___ Yes	___ No	Pain around ear (ringing)	___ Yes	___ No
Dry mouth	___ Yes	___ No	Sensitivity with teeth	___ Yes	___ No
Grinding or clenching teeth	___ Yes	___ No	Snoring while you sleep?	___ Yes	___ No
Jaw pain	___ Yes	___ No			

HEALTH HISTORY

Physician's Name: _____ Telephone: _____ Date of last visit: _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	___ Yes	___ No	Bruise Easily	___ Yes	___ No
Artificial Heart Valves	___ Yes	___ No	Chemical Dependency	___ Yes	___ No
Pacemaker	___ Yes	___ No	Circulatory Problems	___ Yes	___ No
Heart Attack	___ Yes	___ No	Cortisone Treatments	___ Yes	___ No
Any metal pins in the body?	___ Yes	___ No	Cough (persistent or bloody)	___ Yes	___ No
Any implants in body (i.e. breast)?	___ Yes	___ No	Do you wear contact lenses?	___ Yes	___ No
High Blood Pressure	___ Yes	___ No	Epilepsy	___ Yes	___ No
Artificial Joints (i.e. knee, hip)	___ Yes	___ No	Fainting or Dizziness	___ Yes	___ No
Diabetes	___ Yes	___ No	Headaches	___ Yes	___ No
Radiation Treatment	___ Yes	___ No	Herpes	___ Yes	___ No
Cancer-Type: _____	___ Yes	___ No	Liver Disease	___ Yes	___ No
Chemotherapy	___ Yes	___ No	Low Blood Pressure	___ Yes	___ No
Ulcerative Colitis	___ Yes	___ No	Psychiatric Care	___ Yes	___ No
Heart Problems	___ Yes	___ No	Respiratory Disease	___ Yes	___ No
Hepatitis-Type: ____	___ Yes	___ No	Sinus Trouble	___ Yes	___ No
Kidney Disease	___ Yes	___ No	Stroke	___ Yes	___ No
Anemia	___ Yes	___ No	Thyroid Problems	___ Yes	___ No
Arthritis/Rheumatism	___ Yes	___ No	Tuberculosis	___ Yes	___ No
Asthma	___ Yes	___ No	Stomach Ulcer	___ Yes	___ No
Back Problems	___ Yes	___ No	Venereal Disease	___ Yes	___ No
Bleeding Abnormally (with extractions or surgery)	___ Yes	___ No	Weight Loss (unexplained)	___ Yes	___ No
Blood Disease (Transfusions)	___ Yes	___ No	**Have you ever taken or are you taking osteoporosis medications? (i.e. Bisphosphonates, Fosamax, etc.)**	___ Yes	___ No

Women:

Are you pregnant? ___ Yes ___ No Due date: _____
Are you nursing? ___ Yes ___ No
Taking birth control pills? ___ Yes ___ No

MEDICATIONS

List of medications you are currently taking and correlating diagnosis:

NONE: PLEASE INITIAL HERE IF NO MEDICATIONS ARE TAKEN AT THIS TIME _____

ALLERGIES

___ Aspirin
___ Codeine
___ Amoxicillin
___ Penicillin
___ Clindamycin
___ Local Anesthetic
___ Sulfa
___ Latex
___ Other _____
___ **NONE**

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the doctor of any change in my health or medication.

Patient Signature: _____ **Date**: _____

Patient's blood pressure reading today:_____

Reviewed by Doctor (Signature): _____ **Date**: _____

Financial Agreement:

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best material and technology available on the market today. We are also committed to providing you with up-to-date information and education tools that you may fully utilize in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Our office is not a party to that contract. As a courtesy, we will submit insurance claims on your behalf. You may direct your insurance company to pay your benefits to our office by signing the authorization on the Assignment and Release agreement. If the insurance payment is not received within sixty (60) days from the date of service, you will be expected to pay the balance in full.

_____ (initial)

Your estimated copayment for treatment, which is the amount not covered by your insurance, is due at the time of service. Your copayment may be adjusted after the time of service depending on the final reconciliation of insurance payments. Our office accepts cash, personal checks and most major credit cards. Third-party financing is available upon request and approval. Returned checks and balances older than sixty (60) days will be subject to collection fees and finance charges at the rate of 1.5% per month
(18% annually).

_____ (initial)

Appointment Policy (cancellation/change of appointment):

Everyone's time is valuable. We strive to be available when you need us, and we stay on-time for your appointments. We appreciate your courtesy by keeping these appointments. As allowed by state law, there will be a charge for appointments that are not kept or cancelled without a minimum of forty-eight (48) hours' notice.

_____ (initial)

General Consent:

I give consent for the doctor and staff of this office to perform dental treatment. This includes and may not be limited to: x-rays, dental cleanings and administration of local anesthesia.

_____ (initial)

HIPAA:

I have been provided an opportunity to review the Notice of Privacy Practices and understand I will receive a copy upon request.

_____ (initial)

_____ _____

Print Name of Patient or Responsible Party **Date of Birth**

_____ _____

Signature **Date**

Please print and bring this completed form to your appointment, OR you can email it to office@irvinesmiledesign.com.
Additionally, if you would like to utilize insurance for your dental appointment,
please include a photo of the front and back of your insurance card.
Thank you and we look forward to meeting you!